Claims Payment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
11201	**Perform EDI Oversight**	The costs related to the establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic billing, remittance advice, eligibility query, claims status query, and other purposes; and/or between Medicare and a bank for electronic funds transfer or remittance advice. **Reference:** • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Sections 3021, 3022, and 3023 to the extent these manual references were not overridden by one of the listed PMs. • PM B-02-079 • PM AB-01-96 • PM AB-01-133 • PM AB-02-020 • CR 2547 • CR 2576	a. Obtain valid EDI and EFT agreements, provider authorizations for third party representation for EDI, and network service agreements. Enter the data into the appropriate provider-specific and security files, and process reported changes involving those agreements and authorizations b. Issue/control/update/monitor passwords and EDI billing/inquiry account numbers c. Sponsor providers and vendors to establish IVANS, other private network, and LU 6.2 connections where supported. d. Systems test with electronic providers/agents to assure compatibility for the successful exchange of data e. Submit EDI data, HIPAA implementation status, and submitter HIPAA testing status reports f. Monitor and analyze recurring EDI submission and receipt errors, and coordinate with the submitters and receivers when necessary to eliminate errors g. Investigate high provider eligibility query to claim ratios and initiate corrective action as needed h. Maintain a list on your web page of software vendors whose EDI software has successfully tested for submission of transactions to Medicare i. Furnish support to providers on the use of the free/low cost billing software j. Furnish basic support to providers on interpretation of transactions issued by Medicare	

Claims Payment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
11202	**Manage Paper Bills/Claims**	All costs related to the receipt, control, and entry of paper claims and for maintenance of the standard paper remittance advice format This activity encompasses tasks prior to and following the shared system process. **Reference:** • MCM Part 2, Chapter 3, Section 5240 • MCM Part 3, Sections 2010, 3005, 4020-4025 • PM B-01-76	a. Receive, open, sort and distribute incoming claims b. Assign control numbers and date of receipt c. Image paper claims and attachments d. Perform data entry (whether manual or electronic scanning) e. Identify claims that cannot be processed due to incomplete information f. Resolve field edit errors g. Return incomplete paper claims or paper claims that failed pre-shared system edits to providers for correction and resubmission h. Re-enter corrected/developed paper claims i. Update the standard paper remittance advice format annually	**Workload 1** is the difference between the total claims reported on the HCFA-1565, Page 9, Line 38, Column 1 minus the EMC claims reported in Line 38, Column 6.
11203	**Manage EDI Bills/Claims**	Establish, maintain, and operate the infrastructure for EDI and DDE , as supported, for claims, remittance advice, status query, eligibility query, and EFT. Requires 1 upgrade per year in each of the EDI formats supported, free billing software, and related tasks. **Reference:** • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Sections 3021.1, .2, .3, .4, • MCM, Part 3, Sections 3022, 3023, 3024 and 3025 to the extent these manual references were not	a. Provide free billing software, PC-Print software, and update once per year b. Alpha test and validate the free billing software c. Assist with resolution of problems with telecomm protocols and lines, and your software and hardware to maintain connectivity with partners d. Maintain capability for receipt and issuance of transactions via DDE, where supported, and in batches e. Maintain EDI access, syntax, and semantic edits at the front-end, prior to shared system processing f. Route edit and exception messages, claim acknowledgements, claim development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic mailbox for downloading by the trading partners; route EFTs; and receive 997 transactions from trading partners reporting errors in transactions g. Verify the validity of the EDI data received from electronic trading partners through selective audits and use of other verification tools	**Workload 1** is reported on the HCFA-1565, Page 9, Line 38, Column 6.

CAFM Code	Activity Name	Definition	Tasks	Workload
		overridden by one of the listed PMs • MCM, Part 1, Chapter 4, Section 4430 • PM B-00-68 • PM B-01-06 • PM B-01-32 • PM B-01-35 • PM B-01-71 • PM B-01-76 • PM AB-01-29 • PM AB-02-054 • PM AB-02-067 • PM AB-02-133 • PM AB-02-142 • PM AB-02-166 • PM AB-03-012 • PM AB-03-026 • PM AB-03-029 • CR 2576 • CR 2579 • CR 2581 • CRs pending release: post 276/277 and NCPDP (DMERCs) companion documents on the web, DMERC flat file expansion to accommodate NCPDP decimal in excess of two, and specifying changes to be made to the systems under the 1-update a year rule.	h. Maintain back-end edits to assure remittance advices and query responses comply with the implementation guide requirements, and EFTs comply with the ACH or 835 requirements i. Create a copy of EDI claims as received and have the ability to recreate each outgoing remittance advice and COB transaction j. Maintain audit trails to document processing of EDI transactions k. Translate transaction data between pre-HIPAA and HIPAA standard formats and the corresponding shared system flat files l. Update claim status and category codes, claim adjustment reason codes, and remittance advice remark codes m. Bill third parties for electronic access to beneficiary eligibility data, maintain receivables for those accounts, and terminate third parties for non-payment	

Claims Payment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
11204	**Bills/Claims Determination**	Most of the costs related to the determination of whether or not to pay a claim after claim entry and initial field edits are automated and captured under the Run Systems activity. However, operational support staff is required to support claims pricing and payment in conjunction with the programming activities included under Run Systems. Costs of these support activities, which include the creation, maintenance, and oversight of reasonable charge screens, fee schedules, and other pricing determination mechanisms that support claims processing systems, are reported under the Bills/Claims Determination activity. Also, the cost of any staff intervention in the adjudication of claims resulting from automated claims payment edits should be assigned to this activity. **Reference:** • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Chapter 3, Sections 3000-4000 • MCM, Part 3, Section 4630	a. Maintain fee schedule (local variations) b. Check for duplicates c. Identify claims that have to be resolved manually d. Re-enter corrected/developed claims that suspend from the standard system e. Resolve edits on claims that cannot be processed (if possible) f. Maintain pricing software modules g. Update HCPCS, diagnostic codes, and other code sets that impact pricing as needed	**Workload 1** for adjudicated claims is the difference between the cumulative number of claims processed reported on the HCFA-1565, Page 1, Line 15, Column 1 minus Line 16, Column 1 (replicates).

Claims Payment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
		• PM B-01-60		
11205	**Run Systems**	The costs of procurements and the programmer/management staff time associated with the systems support of claims processing outside those provided by the standard system maintainer under direct contract to CMS. It also includes, but is not limited to: data center costs for Bills/Claims Payment; local CPU costs for claims processing (including those associated with the application of MIP edits); validating new software releases; maintaining interfaces and testing data exchanges with standard systems, CWF, HDC, State Medicaid Agencies; maintaining the Print Mail function, on-line systems, telecommunications systems, and mainframe hardware; providing LAN/WAN support; and ongoing costs of transmitting claims data to and from the CWF host, as well as other telecommunications costs. **Reference:** • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Chapter 3, Sections 3000-4000	a. Test releases b. Assign Data Center costs c. Purchase software/hardware d. Generate data for MSNs/EOMBs/NOUs, paper remittance advices, and paper checks *(Note: any associated printing and mailing costs will be included in the "Manage Outgoing Mail" activity*) e. Manage change requests	

Claims Payment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
11206	**Manage IS Security Program**	The costs necessary to adhere to the CMS information systems security policies, procedures and core security requirements, re: the CMS Business Partner Systems Security Manual (BPSSM). **Reference:** • BPSSM Section 2.2 • BPSSM Section 3.1 • BPSSM Section 3.2 • BPSSM Section 3.3 • BPSSM Section 3.4 • BPSSM Section 3.5.1 • BPSSM Section 3.5.2 • BPSSM Section 3.6 • BPSSM Section 3.7 • BPSSM Section 3.8	a. Principal Systems Security Officer (PSSO) staffing (including support staff), and training and supporting PSSO functions and responsibilities (Section 2 of the BPSSM) b. Conduct an annual self-assessment using CAST (A-2 of the BPSSM) c. Develop, review and update the systems security plans (Section 3.1 of the BPSSM) d. Conduct, review and update the Information System Risk Assessment (Section 3.2 of the BPSSM) e. Prepare the annual systems security component of internal control certification (Section 3.3 of the BPSSM) f. Prepare, review, update and test the information technology systems contingency plan (Section 3.4 of the BPSSM) g. Conduct an Annual Compliance Audit and implement Corrective Action Plans to resolve resultant findings (Section 3.5 of the BPSSM) h. Develop Computer Incident Reporting and Response Procedures (Section 3.6 of the BPSSM) i. Develop and maintain a system security profile (Section 3.7 of the BPSSM)	
11207	**Manage TPAs to Accomplish Coordination of Benefits with Supplemental Payers and States**	The costs associated with the solicitation and execution of agreements for the purpose of crossing paid claims data to health care insurers; continuation of activities related to the cross over Medicare paid claims data to new and existing trading partners; and collection of fees. **Reference:** • MCM, Part 1, Chapter 6, Section 4601 • PM AB-02-095	a. Market, execute and maintain CMS's Standard Trading Partner Agreement (TPAs) for COB purposes b. Perform billing/collections functions for crossover activities to ensure that electronic Medigap insurers and electronic non-Medigap (i.e., complementary) insurers, as well as paper Medigap insurers, are charged the appropriate rates established by CMS c. Perform internal and external systems support and testing d. Maintain information to answer inquiries regarding crossover claims e. Resolve problems with trading partners and impacted providers f. Resolve COB processing problems (e.g., in matching data and transmitting files)	**Workload 1** is the number of claims transferred as designated in the MCM 4361.10. (Currently only reported on the FACP). **Workload 2** is the number of TPAs executed in this fiscal year.

CAFM Code	Activity Name	Definition	Tasks	Workload
		• PM AB-03-066		
11208	**Conduct Quality Assurance**	The costs related to routine quality control techniques used to measure the competency and performance of claims processing personnel; quality assurance reviews of fee schedules, HCPCS and ICD-9 updates and maintenance; and review of contractor systems. **Reference:** • MCM, Part 1, Section 4213 • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Sections 7032.3 • MCM, Part 3; Section 13360.1 • MCM, Part 3, Section 14002 • MCM, Part 3, Section 15023	a. Review suspended/reopened claims for correct processing b. Review processed paper/EMC claims for accuracy c. Perform other QC sampling techniques for claims processing d. Perform QA on fee schedules maintenance and contractor systems	
11209	**Manage Outgoing Mail**	The costs to manage the outgoing mail operations for the bills/claims processing function (e.g., costs for postage, printing NOUs/MSNs/EOMBs, remittance advices and checks, and paper stock). **Reference:** • MCM, Part 3, Section 3023 • MCM, Part 3, Section 7030	a. Mail NOUs/MSNs/ EOMBs, paper remittance advices, and checks b. Mail requests for information (other than medical records or MSP) to complete claims adjudication c. Return unprocessable claims to providers d. Return misdirected claims e. Forward misdirected mail	

CAFM Code	Activity Name	Definition	Tasks	Workload
		• MCM, Part 1, Chapter 4, Section 4430 • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Sections 7051-7055 • PM B-99-22 • PM B-99-42 • PM B-00-13 • PM B-01-03 • PM B-01-35 • PM B-01-76 • PM AB-00-65 • PM AB-01-124		
11210	**Reopen Bills/Claims**	The costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error, inaccurate coding, input error, misapplication of reasonable charge profiles and screens, etc. **Reference:** • MCM, Section 12100	a. Receive written inquiry or referral for reopening b. Control and image claim c. Research validity of issues related to the reopening d. Adjust claim as appropriate e. Issue response related to claims determination if necessary (e.g., a revised NOU or EOMB) f. Refer to other areas if appropriate to the circumstances g. Document and maintain files for appropriate retrieval	
11211	**Non-MSP Carrier Debt Collection/**	The costs incurred in the recovery of all Part B Program Management overpayments by	a. Initiate the prompt suspension of payments to providers to assure proper recovery of program overpayment and reduce the risk of uncollectible accounts	

Claims Payment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
	Referral	carriers in accordance with applicable laws and regulations. *(Note: the costs of developing an overpayment should be captured in the respective budget area from which it was generated).*	b. Verify bankruptcy information for accuracy and timeliness c. Coordinate with CMS/OGC and update the PSOR to ensure proper treatment and collection of overpayments d. Refer eligible debt to Treasury e. Review all extended repayment plan requests (ERPs) f. Coordinate with CMS on ERPs	

Provider/Supplier Enrollment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks*	Workload
31001	**Provider Enrollment**	Provider/supplier enrollment is a critical function to ensure only qualified and eligible individuals and entities are enrolled in the Medicare program. Physicians, non-physician practitioners and other healthcare suppliers must enroll with the Medicare Carriers, with whom they will do business, before receiving payment for services furnished to beneficiaries. Each applicant will use the appropriate enrollment form and undergo the entire enrollment process, including verification of their information. **Reference:** • PIM, Chapter 10*	a. Distribute all enrollment applications or refer the applicant to the CMS web site. (§2.2) b. Process initial applications (CMS 855I and CMS 855B) from receipt to final decision, including verification and meeting the CMS timeliness standards. (§1 - 5, 8, 9, 15 - 21, 25) c. Process, verify and acknowledge changes of information within the CMS timeliness standards. (§3, 13) d. Process and verify reassignment of benefits requests, (CMS 855R) within the CMS timeliness standards. (§7) e. Verify and document FID, HIPDB, Qualifier.Net, etc. (§2.2) f. Image applications (i.e., for authorized representative and delegated official signatures) or maintain a hardcopy file to compare the signatures of the authorized representative and delegated official. (§2.2) g. Enter all application information into the Provider Enrollment, Chain and Ownership System (PECOS). (§2.2) h. Deactivate and reactivate billing privileges. (§3) i. Ensure staff is trained on enrollment requirements, procedures and techniques. (§2) j. Respond to all phone calls and miscellaneous letters concerning enrollment in the Medicare program. Provider enrollment-initiated educational projects should be charged to provider enrollment. Activities done in conjunction with the Provider Communications (PCOMM) group should be charged to the PCOMM line. (§22) k. Provide a link to the CMS web site from your contractor web site. (§23)	**Workload 1** is the number of initial application requests (CMS 855B, CMS 855I) received in a month that is available in PECOS. This includes the number of enrollment records established to process the change of information/updates. **Workload 2** is the number of change of information requests (CMS 855I, CMS 855B) received in a month that is available in PECOS. **Workload 3** is the number of Reassignment of Benefit requests (CMS 855R) received in a month that is available from PECOS.

Provider/Supplier Enrollment Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks*	Workload
			l. Communicate with the UPIN Registry, to include review, update and corrections of records. (§2) m. Initiate special projects as necessary or as requested by CMS. n. Coordinate with other internal components (e.g., appeals, fraud unit, EFT processor, provider education/professional relations, ROs etc.). For EFTs, only charge provider enrollment for the mailing in the new provider packet and the verification of the bank account per MCM §3060 and §3488. (§2) o. Coordinate with other external components (e.g., OIG, Medicaid, FBI, Payment Safeguard Contractors (PSCs), etc.). When working with PSCs, the carrier will charge their assistance to a PSC under one of the three designated workloads (see activity code 23201). Work not associated with one of these workloads is charged to provider enrollment. (§2) p. Perform site visits for IDTFs and other problematic suppliers. (§18) q. The RailRoad Retirement Board (RRB) enrollment will contact a carrier(s) for additional information for the development of provider enrollment information needed to process RRB claims. The carrier(s) may have to create an enrollment record in PECOS. Carrier(s) are to respond to RRB inquiries within 10 days. r. Arrange for or conduct hearings for provider enrollment appeals.	

Appeals Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
12090	**Part B Quality Improvement/ Data Analysis**	All costs and workloads associated with appeal quality improvement and data analysis. **Reference:** • PM AB-03-067	a. Identify reasons for full or partial reversals and dismissals b. Identify denials due to medical review edits c. Identify providers/suppliers with high review rates and high reversals d. Identify problems/issues that have the highest rate of appeal or reversal e. Identify percentage of each level of appeal that result in full reversals, partial reversals, and affirmations f. Report on claims processing system errors, provider errors, and delayed documentation submission that result in denials and the potential affect on appeals review requests g. Forward the results of data analysis and any recommendations to appropriate components (e.g. Medical Review, Provider Education, etc.) h. Take corrective action as needed i. Perform Quality Control Checks as instructed in the PM. j. Create and maintain an effective system for internal feedback loops k. Submit reports to CMS as specified in official instructions	
12141	**Telephone Reviews**	All costs and workloads associated with conducting telephone reviews. Telephone reviews are those reviews that are requested by telephone and subsequently completed over the telephone. **Misc. Code**: 12141/01 – **Dismissals/Withdrawals of Telephone Reviews** – All costs associated with processing telephone reviews that are dismissed or withdrawn.	a. Take all pertinent information for review request over the telephone b. Determine if the review can be handled over the telephone c. Log Request into system and assign control number d. Enter data as necessary into system/database e. Conduct the review over the telephone and evaluate evidence/case history f. Make a review determination g. Write a review determination letter (if wholly or partially unfavorable), if beneficiary initiated write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable) h. Mail a review decision letter to parties i. If decisions partially or wholly reversed, effectuate decision	**Workload 1** Telephone Review Requests Cleared (claims) (CMS-2590, Line 7, Column 2) **Workload 2** Telephone Review Requests Cleared (cases) (CMS-2590, Line 6, Column 2)

Appeals Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
		Reference: • MCM, Part 3, Chapter 12, Section 12013	j. Enter case status information throughout the process of this activity and update as necessary	**Workload 3** Telephone Review Reversals (cases) (CMS-2590, Line 11, Column 2)
12142	**Written Reviews**	All costs and workloads associated with completing a written review. Written reviews are those reviews that are requested by telephone or in writing and subsequently completed in writing. **Misc. Code**: 12142/01 – **Dismissals/Withdrawals of Written Reviews** – All associated with processing written reviews that are dismissed or withdrawn. **Reference:** • §1869 and §1842(b)(2)(B)(i) of the Social Security Act • 42 CFR 405.807 – 405.812 • MCM, Part 3, Chapter 12, Section 12012	a. Receive written review request in corporate mailroom and date stamp request b. Assign contractor control number (CCN) to review request c. Scan review request and any other documentation, if applicable d. Forward review request to appropriate department and date stamp with department name e. Begin review case preparation and validate request f. Enter data as necessary into system/database g. Evaluate evidence and case history of review request h. Obtain consultant/RN/specialist opinion for review request, if necessary i. Write or call appellant to request additional documentation for the review, if necessary j. Receive, scan and control additional documentation for review, if necessary k. Make a determination about the review request l. Write a review determination letter (if wholly or partially unfavorable), if beneficiary initiated write a decision letter at appropriate reading level, issue an EOMB/MSN/RA (if wholly or partially favorable) m. Mail review determination letter to parties, if applicable n. If decision is partially or wholly reversed, effectuate decision (make payment) and update records o. Enter case status information throughout the process of this activity and update as necessary, maintain/story case file for possible HO Hearing Request	**Workload 1** Written Review Requests Cleared (claims) (CMS-2590, Line 7, Column 1 minus Line 7, Column 2) **Workload 2** Written Review Requests Cleared (cases) (CMS-2590 Line 6, Column 1 minus Line 6, Column 2) **Workload 3** Written Review Requests Reversed (cases) (CMS-2590, Line 11, Column 1 minus Line 11, column 2)

Appeals Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
12143	**Incomplete Review Requests**	All costs and workloads associated with handling incomplete or unclear review requests. **Reference:** • MCM, Part 3, Chapter 12, Section 12012.1(B)(2) for what constitutes a review request	a. Receive unclear or incomplete request from provider or state b. Return it with clarification of what is required for a review request c. Maintain a count of all review requests that are returned and enter this count into CAFMII	**Workload 2** Incomplete Review Requests (cases) (not currently captured on the CMS-2590)
12150	**Part B Hearing Officer Hearings**	All costs and workloads associated with processing, and conducting on-the-record, telephone, and in-person Hearing Officer (HO) Hearings. All costs and workloads associated with processing a dismissal/withdrawal of a Hearing Officer Hearing request. **Reference:** • § 1869 and §1842(b)(2)(B)(ii) of the Social Security Act • 42 CFR 405.821 - 405.836 • MCM, Part 3, Chapter 12, Section 12017 • MCM, Part 3, Chapter 12, Section 12018 • MCM, Part 3, Chapter 12, Section 12019	a. Receive HO hearing request in mailroom or by phone b. Assign contractor control number (CCN) to HO hearing request c. Scan HO hearing request and any other documentation, if applicable d. Forward HO hearing request to appropriate department and date stamp with department name e. Begin HO hearing case preparation and validate request f. Enter data as necessary into system/database g. Write and send an HO hearing acknowledgement letter h. Prepare the HO hearing case file i. Schedule the hearing j. Provide written notice of the hearing k. Pre-examine the HO hearing evidence l. Enter data as necessary into systems/database m. Examine the applicable sections of the statues, regulations, rulings, policy statements, general instructions and formal guidelines to prepare for the HO hearing n. Travel o. Conduct the HO Hearing p. Receive medical review for the HO hearing, if necessary q. Make a determination about HO hearing request r. Write and mail a HO hearing decision letter to appellant s. Effectuate the decision if whole or partial reversal	**Workload 1** HO Hearing Requests Cleared (claims) (CMS-2590, Line 7, Column 3) **Workload 2** HO Hearing Requests Cleared (cases) (CMS-2590, Line 6, Column 3) **Workload 3** HO Hearings Reversed (cases) (CMS-2590, Line 11, Column 3)

CAFM Code	Activity Name	Definition	Tasks	Workload
			t. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for possible ALJ request	
12160	**Part B ALJ Hearings**	All costs and workloads associated with the processing of ALJ hearing requests, decisions, and effectuations. All costs associated with processing DAB referrals, DAB requests and DAB effectuations **Reference:** • 42 CFR 405.855 and 42 CFR 405.856 • MCM, Part 3, Chapter 12, Section 12026 • MCM, Part 3, Chapter 12, Section 12032 • PM AB-02-126 **Misc. Code:** 12160/01 – **Courier Service Fee** – All costs of using a courier service to forward requests for Part B ALJ hearing and case files. **Reference:** • **AB-02-126**	**For Part B ALJ requests and effectuations** a. Receive written ALJ hearing requests and requests from the DAB for case files b. Assign contractor control number (CCN) c. Scan requests, referrals, and any other documentation, if applicable d. Forward ALJ hearing request to appropriate department and date stamp with department name e. Enter data as necessary into system/database f. Prepare and send an acknowledgement letter g. Assemble case file and make and maintain an exact copy of the file h. Forward case file to appropriate OHA location (for ALJ hearing requests), and send case files to the DAB as requested i. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals j. Receive and control case file and decision k. Compute the amount due to the appellant/party based on the decision (if whole or partial reversal (make payment) l. Enter data as necessary into system/database m. Effectuate decision if whole or partial reversal n. Place documentation confirming payment has been made in the case file, if applicable o. Place documentation confirming payment has been made in case file, if applicable p. Enter case status information throughout the process of this activity and update as necessary, maintain/store case file for potential future appeals **For Part B DAB referrals, requests for case files and**	**Workload 1** ALJ Hearing Requests Forwarded (claims) (CMS-2590, Line 45, Column 1) **Workload 2** ALJ Hearing Requests Forwarded (cases) (CMS-2590, Line 44, Column 1) **Workload 3** ALJ Hearings Effectuated (cases) (CMS-2590, Line 58, Column 3)

Appeals Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
			effectuations: a. Prepare draft Agency Referral memo and case file, and forward to lead RO within 30 days of the date of the ALJ decision b. Receive and control the appellant's DAB review request or the DAB's request for a case file c. Retrieve case file d. Copy any additional correspondence and make a copy of the original case file and maintain e. Send original case file to the DAB f. Effectuate DAB's decision g. Enter case status information throughout the process of this activity and update as necessary	

Beneficiary Inquiries Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
13002	**Beneficiary Written Inquiries**	All costs associated with answering beneficiary/Congressional questions through correspondence. **Reference:** • MCM, Part 2, Chapter 2, Section 5104.B.	a. Log/Control and stamp all written inquiries with receipt date in mailroom b. Answer Inquiry in writing, via telephone, or e-mail c. Send Response d. Maintain Quality Control Program for written policies and procedures e. Transfer misrouted correspondence f. Establish a correspondence Quality Control Program g. Perform continuous quality reviews of outgoing letters	**Workload 1** is the cumulative inquiries as reported on the CMS-1565, Line 27, Beneficiary Column.
13003	**Walk-In Inquiries**	All costs associated with answering questions from beneficiaries visiting the Medicare Contractor facility. **Reference:** • MCM, Part 2, Chapter 2, Section 5104.C.	a. Maintain sign–in sheets for walk-in individuals b. Keep records of contact by recording facts, questions, and responses given to individual c. Conduct inquiry interview d. Provide Medicare publications, as required	**Workload 1** is the cumulative inquiries as reported on the CMS-1565, Line 26, Beneficiary Column.
13004	**Customer Service Plans**	All costs associated with providing beneficiary outreach and educational seminars, conferences, and meetings for contractor's entire geographic area and not limited to the local RO.	a. Establish partnerships and collaborate with local and national coalitions and beneficiary counseling and assistance groups b. Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries c. Conduct Medicare awareness training/education with appropriate Congressional staffs to resolve beneficiary issues with Medicare	

Beneficiary Inquiries Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
13005	**Beneficiary Telephone Inquiries**	All costs associated with answering beneficiary/Congressional questions over the telephone. All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response. All costs associated with planning/conducting training; and inputting/reviewing performance data. All costs associated with purchasing and maintaining telephone systems and equipment (e.g. IVRs). **Reference:** • MCM, Part 2, Chapter 2, Section 5104.A.	a. Answer telephones b. Completing internal paperwork c. Inputting data into the system d. Analyzing reports and data e. Mailing information requested f. Making follow-up calls g. Monitoring Call h. Completing Scorecard i. Inputting Scorecard j. Reviewing Scorecard with CSR k. Planning/conducting training for CSRs	**Workload 1** is the cumulative inquiries as reported on the CMS-1565, Line 25, Beneficiary Column.

Beneficiary Inquiries Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
13201	**Second Level Screening of Complaints Alleging Fraud and Abuse**	Costs associated with screening second level inquiries of potential fraud and abuse that are closed for beneficiaries, ordering medical records for beneficiary inquiries that are closed, and sending the referral package to the PSC or Medicare fee-for-service contractor BIU. This also includes the costs associated with the referral package for provider inquiries of potential fraud and abuse. Workload associated only with beneficiaries. **Misc. Code:** 13201/01 - **Second Level of Complaints Alleging Fraud and Abuse by Providers** – Costs and workload associated with the referral package for provider inquiries of potential fraud and abuse.	The tasks below are associated with beneficiary inquiries only. a. Calls the beneficiary (CR 2719) b. Reviews claims history (CR 2719) c. Reviews provider correspondence files for educational/warning letters or contact reports that relate to similar complaints (CR 2719) d. Requests itemized billing statements, when necessary (CR 2719) e. Requests medical records, when necessary (CR 2719) f. Resolves complaints, whenever possible (CR 2719) g. Refers complaints that are not fraud and abuse to the appropriate staff within the contractor or PSC, if appropriate (CR 2719) h. Screens all Harkin Grantee complaints for fraud and abuse (CR 2719) i. Screens all OIG Hotline complaints for fraud and abuse (CR 2719) j. Develops the referral package for the PSC on fraud and abuse complaints (CR 2719) k. Refers the referral package to the PSC within 30 calendar days of receipt of the complaint in the AC mailroom, or within 30 calendar days of receiving medical records (CR 2719) l. Maintains statistics and reports, as required (CR 2719)	**Workload 1** is the total number of complaint screening inquiries. **Workload 2** is the total number of medical records ordered. **Workload 3** is the total number of fraud complaints identified and referred to the PSC.

Provider Inquiries Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
33001	**Answering Provider Telephone Inquiries**	All costs associated with answering provider questions over the telephone. **Reference:** • MCM, Part 2, Chapter 2, Section 5105.C.1-4, MCM, Part 2, Chapter 2, Section 5105.C.6, MCM, Part 2, Chapter 2, Section 5105.C.9-12, MCM, Part 2, Chapter 2, Section 5105.D.1-3.	a. Answering the phones timely b. Completing internal paperwork c. Inputting data into the system d. Analyzing reports and data e. Sending requested information f. Making follow-up calls g. Implementing a provider satisfaction survey h. Developing a contingency plan i. Developing an IVR quality assurance plan j. All costs associated with purchasing and maintaining telephone systems and equipment	**Workload 1** is the cumulative inquiries as reported on the HCFA-1566, Line 35, Provider Column
33014	**Quality Call Monitoring Performance Measures**	All costs associated with the monitoring of a Customer Service Representative's (CSRs) telephone skills and the accuracy of the response. **Reference:** • MCM, Part 2, Chapter 2, Section 5105.C.7-8.	a. Monitoring Calls b. Completing Scorecard c. Inputting Scorecard d. Reviewing Scorecard with CSR e. Implementing remote monitoring capabilities	
33020	**Staff Development and Training**	All costs associated with the training and development of provider inquiries staff. **Reference:** • MCM, Part 2, Chapter 2, Section 5105.C.5.	a. Planning/conducting training for CSRs b. Attending CMS sponsored meetings, conferences and train-the-trainer sessions related to provider customer service	

Provider Inquiries Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
33002	**Provider Written Inquiries**	All costs associated with answering provider questions through written correspondence. **Reference:** • MCM, Part 2, Chapter 2, Section 5105.A.1-3, MCM, Part 2, Chapter 2, Section 5105.B.	a. Logging/Controlling and date stamping all written inquiries in the mail room b. Responding to a written inquiry in writing, via telephone, or via e-mail c. Mailing the response (if applicable) d. Maintaining a Quality Control Program for written policies and procedures e. Transferring misrouted correspondence f. Maintaining a correspondence Quality Control Program g. Performing continuous quality reviews of outgoing letters	**Workload 1** is the number of provider written inquiries received by the contractor as reported on the CMS-1565, Line 27, Provider Column.
33003	**Provider Walk-In Inquiries**	All costs associated with answering questions from providers visiting the Medicare Contractor facility.	a. Maintain sign–in sheets for walk-in individuals b. Keep records of contact by recording facts, questions, and responses given to individual c. Conduct inquiry interview d. Provide Medicare publications, as required	**Workload 1** is the cumulative inquiries as reported on the CMS-1565, Line 26, Provider Column.

Provider Communications (PCOM-PM) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
14101	**Provider/Supplier Information and Education Website**	All costs associated with maintaining an Internet web-site that is dedicated to furnishing providers and suppliers with timely, accessible and understandable Medicare program information. This includes the costs associated with the development and maintenance of an internet web site. **Reference**: • MCM Part 2, Chapter II, Section 5107, A.7.a., 2004 BPR	a. Develop a website that is consistent with CMS requirements and website functionality b. Periodically review the Web site standards Guidelines for compliance	**Workload 1** is the number of page views at the URL (root) level for your provider education website.
14102	**Electronic Mailing Lists/List-Serv.**	All costs associated with the development and maintenance of electronic list-servs. **Reference:** • MCM Part 2, Chapter II, Section 5107, A.7.b, 2004 BPR	a. Provide registrants via e-mail of important and time sensitive Medicare program information b. Notify registrants of the availability of contractor bulletins c. Ensure that list-serv accommodates all providers/suppliers	**Workload 1** is the total number of contractor provider/supplier PCOM electronic mailing lists. **Workload 2** is the total number of registrants on all the PCOM electronic mailing lists. **Workload 3** is the total messages sent to registrants. (the number of registrants of each listserv multiplied by the number of times used.)

Participating Physician Carrier activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
15001	**Participating Physician**	Funding for the continuation of the Annual Participating Enrollment, Limiting Charge Monitoring Activities and Dissemination of Participation Information remains a priority for CMS for the 2004 fiscal year. All of these activities remain vital functions to the operating efficiency of this agency. **Reference:** • MCM, Part 3, Chapter 7, Section 7552, MCM, Part 3, Chapter 13, Section 13421, MCM, Part 3, Chapter 13, Section 13326, PM–B-02-072, PM-B-98-43.	**Annual Participation Enrollment** a. Print and mail calendar year 2004 participation enrollment packages (consisting of the "Dear Doctor" Announcement, Blank Par Agreement, Fact Sheet and physician fee schedule hardcopy disclosure report) via first class or equivalent mail delivery service b. Process participation enrollments and withdrawals c. Furnish participation data to RRB. d. Furnish participation data to CMS **Limiting Charge Monitoring Activities** a. Investigate/develop beneficiary-initiated limiting charge violation complaints b. Investigate/develop beneficiary-initiated limiting charge violation complaints. c. Respond to limiting charge inquiries from non-participating physicians d. Internally produce and store limiting charge reports (e.g., LCERs/LCMRs) e. Submit quarterly reports for internally produced limiting charge reports. (MCM 13326ff) **Disseminate Participation Information** a. Furnish customized participation information (either by phone or in writing) in response to requests for such information b. Discontinue the production and mass distribution of hardcopy MEDPARD directories c. Load MEDPARD information on your Internet website and inform physicians, practitioners, suppliers, hospitals, Social Security Offices, Congressional Offices, PROs, senior citizens	**Workload 1** is the number of participation enrollment packages mailed to providers at a national level as reported in CROWD. **Workload 2** is the number of enrollments and withdrawals processed as reported in CROWD. **Workload 3** is the number of limiting charge reports, violations and complaints processed as reported in CROWD.

Participating Physician Carrier activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
			groups and State area agencies of the Administration on Aging how to access this website Information	

Medical Review Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
21001	**Automated Review**	When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. See PIM Ch. 3 section 5.1 for further discussion of automated prepayment review. **Reference:** • PIM Chapter 3, Section 5.1 • PIM Chapter 11, Section 1.3.1	a. Develop edits b. Implement edits c. Quality Assurance edits d. Generate denial letters if appropriate	**Workload 1** is the number of claims denied in whole or in part. **Workload 2** to the extent that contractors can report claims subject to automated medical review. **Workload 3** is the number of providers subjected to medical review, to the extent a contractor can report this.
21002	**Routine Manual Reviews**	Routine prepayment review requires the intervention of specially trained non-clinical MR staff. **Reference:** • PIM Chapter 3, Section 5.1 • PIM Chapter 11, Section 1.3.2	a. Develop edits b. Implement edits c. Claim review d. Make determination e. Generate denial letter if appropriate	**Workload 1** is number of claims reviewed. **Workload 2** is number claims denied in whole or in part. **Workload 3** is the number of providers subjected to routine review, to the extent a contractor can report this.

Medical Review Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
21007	**Data Analysis**	Data Analysis is the integrated and on-going comparison of claim information, claims data deviations from standard practice, and other related data to identify potential errors. This analysis can be a comparison of individual claim characteristics or in the aggregate of claims submissions. **Reference:** • PIM Chapter 2, Section 2 • PIM Chapter 11, Section 1.4	a. Collect data b. Analyze data and compare c. Verify existence of errors d. Identify potential aberrance's e. Develop edit criteria f. Institute ongoing monitoring and modification of data analysis program components g. Develop and maintain trend reports over at least a two-year period	
21100	**Program Safeguard Contractors (PSC) Support Services**	Contractors must tract and record costs associated with providing medical review related support to PSC. **Reference:** • PIM Chapter 11, Section 1.8	a. Pulling medical records b. Photocopying medical records c. Mailing medical records d. Medical Review reconsideration	
21206	**Policy Reconsiderations and Revision Activities**	Contractors are to update Local Medical Review Policy (LMRP). **Reference:** • PIM Chapter 11, Section 1.5.2	a. Determine need b. Develop draft LMRP change c. Solicit comment d. Compile comments e. Develop final policy f. Distribute policy g. Post LMRP on Website	**Workload 1** report the total number of policies revised. **Workload 2** report the total number of policies that required notice and comment. **Workload 3** report total number of polices revised due to outside request (e.g., beneficiary or provider request.).

Medical Review Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
21207	**MR Program Management**	MR Program Management encompasses managerial responsibilities inherent in managing the Medical Review and Local Provider Education & Training Programs, including development, modification and periodic reports of MR/LPET Strategies and quality assurance activities; planning, monitoring and adjusting workload performance; budget-related monitoring and reporting; and implementation of CMS instructions. **Reference:** • PIM Chapter 11, Section 1.9	a. Develop and periodically modify Medical Review/LPET Strategy b. Develop and modify quality assurance activities, including special studies, Inter-Reviewer Reliability testing, Committee meetings, and periodic reports c. Evaluate edit effectiveness d. Plan, monitor, and oversee budget, including interactions with contractor budget staff and RO budget and MR program staff e. Manage workload, including monitoring of monthly workload reports, reallocation of staff resources, and shift in workload focus when indicated f. Implement Medical Review instruction from Regional and/or Central Office g. Educate staff on Medical Review issues, new instructions, and quality assurance findings	
21208	**New Policy Development Activities**	Contractors are to create Local Medical Review Policy (LMRP). **Reference:** • PIM Chapter 11, Section 1.5.1	a. Determine need b. Develop draft LMRP change c. Solicit comment d. Compile comments e. Develop final policy f. Distribute policy g. Post LMRP on Website	**Workload 1** is the number of new policies that were presented for notice and comment**.** **Workload 2** is the number of policies that became effective.

Medical Review Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
				Workload 3 is the number of Coverage Statements (National Coverage Decisions that do not require you to develop an LMRP) you published.
21210	**MR Review Reopenings of N102 Claims and Claims with Late Documentation**	Report the costs associated with Contractor MR staff re-processing denials returned from the formal appeals process.	a. Receive reopening request b. Review initial determination c. Request additional documentation (if needed) d. Make determination e. Communicate with provider/supplier	**Workload 1** is the number of reopening requests received as captured by carriers and DMERCs. **Workload 2** is the number of reopenings resulting in payment. **Workload 3** is the number of providers with reopenings.
21220	**Complex Manual Probe Sample Review**	Report all costs associated with prepay and postpay Complex Manual Probe Sample Review.	a. Review data b. Select sample c. Request medical records/additional information d. Review claim e. Make determination f. Generate denial/demand letters, if appropriate	**Workload 1** is the number of claims reviewed. **Workload 2** is the number of claims denied in whole or in part. **Workload 3** is the number of providers subjected to complex review as reported by the carrier and DMERC.
21221	**Prepay Complex Manual Review**	Report all costs associated with Prepay Complex Manual Review.	a. Develop edits b. Implement edits c Claim review d. Request medical records and additional documents	**Workload 1** is the number of claims reviewed. **Workload 2** is the number of claims denied in whole

CAFM Code	Activity Name	Definition	Tasks	Workload
		Misc. Code: 21221/01 (DMERCs Only) – **Advance Determinations of medicare Coverage (ADMC)** – DMERCs are to report all costs associated with performing Advance Determinations of Medicare Coverage. DMERCs are to report the number of ADMC requests accepted. **Reference:** ● PIM Chapter 5, Section 7	e. Claim and Documentation review f. Make determination g. Generate denial letters, if appropriate	or in part. **Workload 3** is the number of providers subjected to complex review as reported by the carrier and DMERC.
21222	**Postpay Complex Manual Review**	Contractors must report all costs associated with Postpay Complex Manual Review.	a. Select claims b. Claim review c. Request medical records and additional documents d. Claim and Documentation review e. Make determination f. Generate overpayment demand letters, if appropriate	**Workload 1** is the total number of claims reviewed on a postpayment basis. **Workload 2** is the toal number of claims denied in whole or in part. **Workload 3** is the number of providers subjected to postpayment review as reported by contractors.

Medicare Secondary Payer (MSP) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
22001	**MSP Bills/Claims Prepayment**	All costs of activities associated to continued processing of a MSP claim after it enters the claims processing system, subsequent to initial claim entry, and activities necessary to aid in the processing of MSP Prepay-related Congressionals and hearings. **References:** • PM AB-03-016 • PM AB-03-020 • PM AB-03-024 • PM AB-02-089 • PM AB-02-107 • PM AB-03-082 • MCM, Part 3, Chapter 2, Section 2370, MCM, Part 3, Chapter 3, Section 3300, MCM, Part 3, Chapter 4, Section 4300, MCM, Part 3, Chapter 13, Section 13450 • PM AB-02-140	a. Resolve MSP claim edits occurring in the claim adjudication process within the standard systems and in response to CWF verification and validation b. Compare EOB/RA data attached to the MSP claim to HIMR/CWF data to identify the presence/absence of a CWF MSP Aux File record and to continue claim processing c. Contact the provider (for clarification- not development) if necessary, to avoid suspending the claim d. Add termination dates to MSP auxiliary records previously established on CWF with a "Y" validity indicator when no discrepancy exists in the validity of the CWF information and an active claim (simple terminations) e. Prepare a CWF Assistance Request to terminate a record only when a system problem exists or it fits existing CWF error codes/subject to the 6-month rule f. Work MSP suspended claims that have not processed through to final payment decision including: - Override a claim using conditional payment codes to process the claim as primary -Prepare an "I" record to accommodate an override -Determine to pay as primary or secondary or deny -*Follow up on COBC development/actions* -Address CWF Automatic Notices g. Complete MSP ECRS Inquiries and CWF Assistance Requests necessary to process the receipt of a claim through to payment or denial – Use C in the ECRS AC field. h. Follow up on prepay CWF Assistance Requests within designated timeframes i. Create "I" records when enough claim information exists to add a new CWF MSP Aux File record j. Process Congressional inquiries and hearings related to MSP Prepay functions and follow up with COBC within designated timeframes	**Workload 1** is the number of MSP claim edits resolved in the claim adjudication and CWF verification and validation processes and the "I" records manually prepared, necessary to complete the processing of a claim. **Workload 2** is the number of ECRS MSP Inquiries and CWF Assistance Requests transmitted to the COBC. **Workload 3** is the number of MSP prepay Congressional and hearing requests processed, including follow up with the COBC.

Medicare Secondary Payer (MSP) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
42002	**Liability, No-Fault, Workers' Compensation, Federal Tort Claim Act (FTCA)**	All costs of activities associated with the identification and establishment of a MSP Recovery claim specific to the named activity. **References:** • MCM, Part 3, Chapter II/ Section 2370's, • MCM, Part 3/ Chapter III Section 3300's, • MCM Part 3, Chapter IV/ Section 4300's • MCM Part 3/ChapterXIII/Section 13450	a. Research Medicare paid claims to identify claims related to a pending settlement, judgment, or award b. Identify Medicare's conditional payment amount c. Issue subsequent conditional payment amount notices (when appropriate) d. Respond to all case related inquiries (includes congressional inquiries) prior to the demand. e. Issue Inter-contractor notices (ICN) requests, as appropriate Respond to ICN requests f. Enter appropriate termination dates to CWF g. Calculate the Medicare recovery amount h. Issue recovery demand to appropriate individual or entity i. Coordinate with RO all pre-demand compromise requests. j. Coordinate with CMS to effectuate FTCA recoveries k. Follow CMS directives for access to OSCAR, UPIN, & NSC data l. Perform appropriate case related ECRS transactions - Use N in the ECRS AC field.	**Workload 1** is the number of recovery demand letters issued. **Workload 2** is the number of incoming Correspondence plus the number of resultant ECRS transactions. **Workload 3** is the number of notices of Medicare's conditional payment amount issued for cases which the contractor has lead responsibility plus the number of ICNs responded to for which you do not have lead responsibility.
42003	**Group Health Plan**	All costs of activities associated with recovery of all Medicare mistaken payments specific to the named activity. **References**: • MCM Part 3/Chapter II/Section 2370's, MCM Part 3/ChapterIII, Section 3300's • MCM, Part 3, Chapter IV, Section 4300's, • MCM, Part 3/Chater XIII, Section 13450 • PM AB-03-082 • PM AB-02-140	a. Install/run Data Match tapes b. Perform all Data Match and Non-Data Match history searches c. Develop & issue recovery demand letters (Data Match, Non-Data Match and DPP demands, as well as, demands resulting from 42 CFR 411.25 notices) taking into account existing search parameters and tolerances, if any d. Check CWF prior to mailing of recovery demands, if contractors' systems will not recognize an existing termination date on an MSP record, to ensure valid MSP periods e. Respond to any pre-demand Data Match & Non Data Match incoming correspondence (including congressionals) related to a case f. Perform all MPARTS status code updates related to actions up to and through the issuance of a recovery demand g. Perform appropriate case related ECRS transactions - Use G in the ECRS AC field.	**Workload 1** is the number of GHP recovery demand letters issued. **Workload 2** is the number of MSP post payment case related ECRS transactions performed.

Medicare Secondary Payer (MSP) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
42004	**MSP General Inquires**	All costs of activities associated to MSP correspondence that is not case or active claim specific. **References:** • MCM, Part 3/, Chapter II, Section 2370's • MCM, Part 3/ Chapter III, Section 3300's, • MCM, Part 3/ Chapter IV, Section 4300's • MCM Part3/ChapterXIII/ • Section13450 • PM AB-03-082 • PM AB-02-140	a. Perform appropriate general (non-case related and non-active claim related) ECRS transactions, including those that may be necessary for voluntary refunds/unsolicited refunds - Use I in the ECRS AC field. b. Take action on non-active claim and non-case related letters (including voluntary refunds/unsolicited refunds), faxes, e-mails, or telephone inquiries c. Respond to one time inquiries for outreach materials which may include the reproduction of these materials (those not counted in 42006) d. Enter non-case related and non-active claim related CWF termination dates e. Respond to OBRA 93 requests not related to an existing debt f. Perform only necessary clerical support for Appeals staff to make determinations	**Workload 1** is the number of general MSP inquiries resolved. This includes OBRA 93 requests. **Workload 2** is the number of non-case related & non-active claim related ECRS transactions performed. **Workload 3** is the number of one-time inquiries requesting outreach materials.

Medicare Secondary Payer (MSP) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
42021	**Debt Collection/ Referral**	All costs of activities associated with the collection of all MSP debts and the referral of eligible delinquent MSP debt under the Debt Collection Act of 1996 **References:** • MCM, Part 3, Chapter II,Section 2370's • MCM, Part 3, Chapter III, Section 3300, • MCM, Part 3, Chapter IV, Section 4300's • MCM Part 3 Chapter VIII/Section 13450 • PM AB-00-11 (CR 899) • PM AB-01-24 (CR 1280) • PM AB-01-83 (CR 1538) • PM AB-02-102 (CR 2145) • PM AB-03-082 • PM AB-02-140	a. Ensure proper recovery of MSP debts b. Respond and resolve all Corr (including congressionals) or other inquiries regarding a debt c. Timely adjudicate and post checks received d. Review and respond timely to "Extended Repayment Plan" (ERP) requests and monitor ongoing ERPs e. Resolve all post demand 1870 waiver requests f. Validate debts using CWF and other available appropriate information before issuing the "Intent to Refer" (ITR) letter g. Issue ITRs to the appropriate individual or entity (includes the acknowledgement letters, and the preparation of CWF assistance requests & ECRS inquiries) h. Resolve all Treasury Action form requests and perform appropriate recall actions, if necessary i. Perform appropriate debt related ECRS transactions (CWF assistance requests & ECRS inquiries) - Use D in the ECRS AC field. j. Refer delinquent debts, as appropriate to Treasury k. Take appropriate referral actions for all compromise or waiver of interest requests l. Develop/complete write-off – closed recommendation report m. Update all appropriate systems that detail the progression of a debt (e.g. MPARTS, DCS, etc.) n. Ensure all MSP report detail are available and complete and can support reported figures (i.e., MSP savings)	**Workload 1** is the number of responses to initial demand letters received from the debtor /agent. **Workload 2** is the number of intent to refer to Treasury letters (ITRs) & the number of responses received from ITRs. . **Workload 3** is the number of referrals to Treasury plus the number of Treasury action forms received.

Benefit Integrity Carrier (Including DMERC) Activity Dictionary
FINAL (Non-PSC Support Services)

CAFM Code	Activity Name	Definitions	Tasks	Workload
23001	**Medicare Fraud Information Specialist (MFIS)**	Costs associated with MFIS activity **Reference:** • PIM chapter 1, section 3.2.5.1 For specific references see the task list.	a. Obtains and shares information on health care issues/fraud investigations (PIM chapter 1, section 3.2.5.1) b. Serves as a reference point for law enforcement and other organizations/agencies (PIM chapter 1, section 3.2.5.1) c. Coordinates and attends fraud related meetings/conferences (PIM chapter 1, section 3.2.5.1) d. Distributes Fraud Alerts and shares contractor findings on them (PIM chapter 1, section 3.2.5.1 and chapter 2, section 4-4.5) e. Works with CMS RO to develop and organize external programs and perform training (PIM chapter 1, section 3.2.5.1) f. Serves as a resource for CMS as necessary (PIM chapter 1, section 3.2.5.1) g. Helps develop fraud related outreach material (PIM chapter 1, section 3.2.5.1) h. Assists in preparation and development of fraud related articles for contractor newsletters/bulletins (PIM chapter 1, section 3.2.5.1) i. Serves as a resource for contractor training (PIM chapter 1, section 3.2.5.1) j. Attends 32 hours of training sessions on training skills, presentation skills, and fraud related training (PIM chapter 1, section 3.2.5.1)	**Workload 1** The number of fraud conferences/meetings coordinated by the MFIS. **Workload 2** The number of fraud conferences/meetings attended by the MFIS. **Workload 3** The number of presentations performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other CMS health care partners.

Benefit Integrity Carrier (Including DMERC) Activity Dictionary
FINAL (Non-PSC Support Services)

CAFM Code	Activity Name	Definitions	Tasks	Workload
23004	**Outreach and Training Activities**	All costs associated with fraud, waste, and abuse outreach and training activities for contractor staff and beneficiaries. Include costs associated with establishing and maintaining fraud, waste, and abuse outreach and training activities for beneficiaries and providers (excluding MFIS activities)	a. Train non-BI staff on proper referral of complaints handled under BI (PIM chapter 2, 3.2.4) b. Initiates and maintains outreach activities with internal and external components as well as outside groups (PIM chapter 1, section 3.2, 3.2.3.1, 3.2.5, 7.3) c. Completion of required fraud training for BI staff (PIM chapter 1, section 3.2.3) d. Provide law enforcement with training as needed (PIM chapter 2, section 3.2.3.1)	**Workload 1** The number of training sessions internal and external furnished only to the BI staff. **Workload 2** The number of face-t made to beneficiaries and provide **Workload 3** The number of training sessions furnished by the contractor BI unit to non-BI contractor staff.
23005	**Fraud Investigation Activities**	Any costs associated with fraud investigation used to substantiate a case.	a. Identify program vulnerabilities (PIM chapter 1, section 3.2) b. Control, verify and document all cases (PIM chapter 1, section 3.2.4.1) c. Document all pertinent contacts, letters, decisions, discussions, etc. Retain records for 7 years (PIM chapter 2, section 3.3) d. Interview providers and beneficiaries (PIM chapter 2, section 3.4.2-3.4.4) e. Conduct onsite reviews (PIM chapter 2, section 3.4.5). f. Determine patterns of fraud (PIM chapter 2, section 2.1) g. Issue Fraud Alerts (PIM chapter 2, section 4) h Coordinate with Medical Review and other internal sources on fraud activities i.. Implement claim payment suspension (PIM chapter 3, section 9) j. Determine exclusion action (PIM chapter 3, section 11.2.2) k. Prioritization of investigations (PIM chapter 1, section 3.2.1)	**Workload 1** The number of investigations opened. **Workload 2** Of the investigations in workload column 1, report how many were opened by the contractor self-initiated proactive data analysis. **Workload 3** The total number of investigations closed (no longer requiring fraud investigation) and which were not referred to law enforcement.

Benefit Integrity Carrier (Including DMERC) Activity Dictionary
FINAL (Non-PSC Support Services)

CAFM Code	Activity Name	Definitions	Tasks	Workload
23006	**Law Enforcement Support**	All BI costs and related data analysis for work done to support law enforcement	a. Receive and respond to all law enforcement requests (PIM chapter 1, section 7-7.1.2)	**Workload 1** The number of law enforcement requests. **Workload 2** The number of requests discussed with the RO. **Workload 3** The number of BI law enforcement requests that require data analysis.
23007	**Medical Review in Support of Benefit Integrity Activities**	All costs associated with medical review (MR) in support of BI activities. The main goal of medical review is to change provider-billing behavior through claims review and education; therefore, any BI initiated review activity that does not allow for provider education or feedback must also be charged to this activity. **Reference:** • PIM chapter 1, section 3, 3.2.4	a. Review of claims by MR and BI (PIM chapter 1, section 4) b. Perform SVRS for overpayment estimation (PIM chapter 1, section 4)	**Workload 1** The number of cases in which the MR unit assisted the BI unit. **Workload 2** The number of claims reviewed by both the MR and BI unit for the BI unit. **Workload 3** The number of statistically valid random samples (SVRS) performed for overpayment estimation by MR in support of BI.

Benefit Integrity Carrier (Including DMERC) Activity Dictionary
FINAL (Non-PSC Support Services)

CAFM Code	Activity Name	Definitions	Tasks	Workload
23014	**Fraud Investigation Database (FID) Entries**	All costs associated with FID entries **Reference:** • PIM	a. Entering new FID cases (PIM) b. Updating FID cases (PIM) c. Entering new payment suspension information (PIM) d. Updating payment suspension information (PIM)	**Workload 1** The total number of new cases entered into the FID. **Workload 2** The total number of cases updated in the FID. **Workload 3** The total number of new payment suspensions entered into the FID.
23015	**Referrals to Law Enforcement**	All costs associated with referrals to law enforcement. **Reference:** • PIM	a. Developing the referral package to law enforcement (PIM chapter 3, section 10.1.4) b. Fulfilling requests for additional information from law enforcement on the referrals they received (PIM)	**Workload 1** The total number of referrals to law enforcement. **Workload 2** The total number of law enforcement referrals requesting additional information by law enforcement. **Workload 3** The number of law enforcement referrals declined.

Benefit Integrity Carrier (Including DMERC) Activity Dictionary
FINAL (PSC Support Services)

CAFM Code	Activity Name	Definition	Tasks	Workload
23201	**PSC Support Services**	The services that the AC will provide to support the BI activities being performed by the PSC (PM). **Misc. Code:** 23201/01 – **Miscellanous support services** - ACs record the total costs associated with miscellaneous PSC support services (e.g. training and meetings). **Misc. Code:** 23201/02 **– Non-Law Enforcement Complaint Development and Investigation Requests –** ACs record the total costs associated with requests (not law enforcement requests) that they fulfill to support the PSC in complaint development and investigations. **Misc. Code:** 23201/03 **– Law Enforcement Requests –** ACs record the total costs associated with PSC requests for support from the AC with law enforcement requests.	a. Prepare referral package b. Prepare/supply additional documentation at the request of the PSC c. Prepare/supply additional documentation at the request of the PSC d. Install edits at the request of the PSC	**Workload 1** Report the total number of miscellanous PSC support services. **Workload 2** AC's record the total number of requests (not law enforcement) to support the PSC in complaint development or investigation. **Workload 3** Report the total number of PSC requests for support from the AC with law enforcement requests.

Local Provider Education and Training (LPET) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
24116	**One-on-One Provider Education**	Contractors must initiate provider one-on-one education in response to coverage, coding and medical review related billing problems identified, verified and prioritized through the analysis of information from various sources and the medical review of claims. These educational contacts require clinical expertise and include face-to-face meetings, telephone conferences, or letters and electronic communications to a provider that address the provider's specific coding, coverage and billing issue. An individualized comparative billing report (CBR) included as part of a specific instructional letter to a specific provider would be considered part of a 'one-on-one' educational contact. The selected educational contacts depend on the level of the coverage, coding or billing error identified. For minor or moderate coverage, coding or billing errors, the educational contact may be made through telephone conferences or an individualized letter iterating the specific problems and cures and including an opportunity for the provider to engage in a teleconference or face-to-face contact. In the case of major coverage, coding or billing errors, the contractor must provide the opportunity for a face-to-face meeting or at a minimum must provide educational services through teleconferencing. In all instances, contractors must supply educational materials to address the provider's specific coverage, coding or billing error. In no instance should the contractor issue general coverage, coding or billing statements without addressing the provider's specific educational need. While one-on-one provider education may correct most coverage,	a. Analyze Data b. Determine appropriate educational method based on scope of problem c. Develop/produce educational information d. Send letter, or electronic communication e. Hold meeting f. Make call	**Workload 1** is the number of providers educated as a result of complex prepay and post pay review. **Workload 2** is the number of providers educated as a result of a probe. **Workload 3** is the number of providers educated as a result of other medical review activity, i.e., data analysis, new provider education, etc.

CAFM Code	Activity Name	Definition	Tasks	Workload
		coding or billing errors in the first educational meeting, providers may require additional remedial education contacts to provide further instruction on coverage, coding or billing requirements.		
24117	**Education Delivered to a Group of Providers**	Education delivered to a group of providers include seminars, workshops, classes, and other face-to-face meetings to educate and train providers regarding local medical review policies, coverage, coding and billing considerations, and service or specialty specific issues. Clinical staff must be used as a resource. Additionally, group settings may be appropriate to address the local educational needs presented by new providers, new coverage policies and bulletin articles concerning medical review issues. Whenever feasible, contractors should collaborate education delivered to a group of providers with interested groups and organizations as well as CMS partners in their service area. **Misc. Code**: 24117/01 - **Group Education Complex MR** - Report costs associated to educate a group of providers as a result of prepay and postpay complex review	a. Analyze Data b. Determine appropriate educational method based on scope of problem c. Gather resources, including clinical staff expertise, and develop/produce educational information d. Select focus groups or site visits/meetings. If feasible, collaborate with partner groups in holding events e. Hold educational meeting with clinical staff in attendance	**Workload 1** is the number of providers educated as a result of a new or modified policy. **Workload 2** is the number of providers educated as a result of a probe. **Workload 3** is the number of providers educated as a result of other medical review activity, i.e., data analysis, and new providers.
24118	**Education Delivered via Electronic or Paper Media**	Education delivered solely via paper media or electronically, without any live interactions is included here. Contractors are required to maintain a website and list serv and adhere to instruction regarding them (PIM Chapter 1, Sec.	a. Analyze Data b. Develop and disseminate web-based searchable FAQs c. Develop and disseminate bulletin articles d. Disseminate and post LMRPs	**Workload 1** is the number of educational projects, developed in whole or in part, as a result

Local Provider Education and Training (LPET) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
		5.9 CR 2466 to be issued.). Examples of this type of education include, but are not limited to, the development and dissemination of frequently asked questions (FAQs), scripted response documents, bulletin articles, LMRP postings, comparative billing reports (CBRs) issued for other than one-on-one provider education.	e. Develop and disseminate CBRs f. Develop and disseminate other types of electronic or paper media education	of prepay and postpay complex medical review. **Workload 2** is the number of educational projects, developed in whole or in part, to be disseminated via paper media. **Workload 3** is the number of educational projects, developed in whole or in part, to be disseminated electronically.

Provider Communications (PCOM-MIP) Carrier Activity Dictionary

FINAL

CAFM Code	Activity Name	Definition	Tasks	Workload
25103	**Create/Produce and Maintain Educational Bulletins**	All costs associated with the development, production and dissemination of provider bulletins/newsletters. **Reference:** • MCM Part 2, Chapter II, Section 5107A.5.	a. Gather resources and information to use in developing bulletin b. Develop bulletin c. Publish bulletin d. Disseminate bulletin	**Workload 1** is the total number of bulletin editions published. **Workload 2** is the total number of bulletins mailed.
25105	**Partner with External Entities**	All costs associated with the establishment and maintenance of collaborative provider education efforts with external entities. **Reference**: • (To be added to Carrier Manual)	a. Contact/communicate with external groups or organizations b. Work with external groups to foster and develop collaborative PET activities c. Obtain feedback on effectiveness and reach of partnering efforts	**Workload 1** is the actual number of partnering activities or efforts with entities other than the PCOM Advisory Committee. **Workload 2** is the actual number of partnering activities or efforts with schools or institutions that teach medical coding **Workload 3** is the actual number of partnering activities with medical practice management organizations
25201	**Administration and Management of PCOM Program**	All costs associated with administering and managing the provider communications program. Includes: analysis and identification of provider educational needs; planning of educational strategies, approaches, or efforts; training of	a. Develop and submit PSP Report b. Develop and submit Quarterly Activity Reports c. Develop and maintain a provider inquiry analysis program d. Tally and analyze claim submission errors e. Solicit and analyze provider feedback f. Hold periodic meetings with other contractor staff to	

CAFM Code	Activity Name	Definition	Tasks	Workload
		staff in support education initiatives; and reporting of provider education activities and efforts. All costs associated with developing plans to outline the strategies, projected activities, efforts, and approaches that will be used in the forthcoming year to support physician/supplier education and training. **Reference:** • MCM Part 2, Chapter II, Section 5107 A.1, 2,3,11, 12 & B.1.	ensure that issues raised by providers are being addressed through education g. Send at least one training representative to between 2-4 CMS-sponsored training events h. Development and research responses to provider referrals	
25202	**Develop Provider Supplier Education Materials and Information**	All costs associated with the planning, design, research, writing and development of materials and information used to support provider education and training efforts. This includes work for new as well as substantially revised materials or information. (These materials do not include bulletins and newsletters.) **Misc. Code:** 25202/01 - **Special Media** for costs associated with preparation of special media. **Reference:** • (To be added to Carrier Manual)	a. Plan materials b. Research needed information c. Design, layout materials d. Write, illustrate or revise material e. Duplicate materials f. Prepare special media educational presentations (discretionary)	**Workload 1** is the number of special media efforts developed.
25203	**Disseminate Provider Information**	All costs associated with holding workshops seminars, classes and other provider education events or	a. Hold workshops, seminars, classes and other face-to-face meetings b. Disseminate Medicare provider information or	**Workload 1** is the number of educational seminars, workshops,

CAFM Code	Activity Name	Definition	Tasks	Workload
		face-to-face meetings. (Does NOT include activities related to creation of bulletins or newsletters.) **Reference**: • MCM Part 2, Chapter II, Section 5107A.6,8.	materials at other provider education events or opportunities	classes and face-to-face meetings held. **Workload 2** is the number of attendees at your educational seminars, workshops, classes and face-to-face training
25204	**Management and Operation of PCOM Advisory Group**	All costs associated with the management and operation of the PCOM Advisory Group (formerly the PET Advisory Group). **Reference:** • MCM Part 2, Chapter II, Section 5107A.4	a. Arrange PCOM Advisory Group meetings b. Solicit and maintain membership c. Obtain materials, supplies and equipment for meetings d. Produce and distribute PCOM Advisory Group information (agenda, minutes, etc.)	